MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (67)

CERTIFICATE OF DEATH

07663 C

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure to give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Came a few minutes.

Hospital, institution, or street address where death occurred:
40 Northwest Street

How long in hospital or institution? Just entered

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Clay Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: George Issaac Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Florine Bell Adams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1908

8. AGE: Years	Months	Days	If less than one day
38	3	11	..... hrs. ..... min.

9. Birthplace: Annapolis, Md. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Barber

FATHER — 12. Name: George Adams

FATHER — 13. Birthplace: Anne Arundel Co.

MOTHER — 14. Maiden name: Nanie Jones

MOTHER — 15. Birthplace: Anna Arundel Co. Annapolis

16. Informant: Mrs Florine Bell Adams

Address: 30 Clay Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-1946 (month) (day) (year)

Cemetery or crematory: National

Location: West Street Extended

18. Funeral director: Ethel L. Hicks

Address: 43-45 Northwest treet

19. August 21 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH: Aug. 17 1946 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated: [redacted]

Post Mortem Examination

and that I last saw deceased on Aug. 18 1946

Immediate cause of death	DURATION
Hemorrhage	
Due to Stab wound thru left carotid	
Due to artery and jugular vein.	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 8/17/46

Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Clay Street

Means of injury Sharp instrument Injured at work? No

23. SIGNATURE John M. Clatty, M.D. Deputy Medical Examiner
M. D. or other

Address Annapolis, Md. Date signed 8/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07664

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
5 Brooke Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Brooke St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Emma May BASIL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 9, 1895

8. AGE: Years	Months	Days	If less than one day
50	11	18	..... hrs. ..... min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name George T. Basil
13. Birthplace Maryland

MOTHER
14. Maiden name Bessie Bell Gregory
15. Birthplace Annapolis, Md.

16. Informant Mr. Thomas G. Basil
Address 5 Brooke St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 29 '46 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Maryland

18. Funeral director Ben L. Hopping

Address 170-172 West St. Annapolis, Md.

19. Aug. 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946, at 11 00 A.M.

21. I CERTIFY that death occurred on the date above stated; [redacted]
POST MORTEM EXAMINATION
[redacted] AUG 27 1946

Immediate cause of death	DURATION
Convulsions	
Due to Epilepsy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Coffey M.D. Deputy Medical Examiner
M. D. or other

Address Annapolis, Md. Date signed 8/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

P 07665 24

Reg. Diat. No. .....

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (Md)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 3 months 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 years 3 months 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1215 Cheltham St 1500 Cheltham

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME Ida Benton (Mary Doe #3)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widow

6.(b) Name of husband or wife: John Benton

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 75 | Months: unknown | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: West Indies (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: .....

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9/4/46 (month) (day) (year)

Cemetery or crematory: Odenton Mem. Pk.

Location: Balto. Md.

18. Funeral director: Joseph B. Locke, Jr.

Address: 1304 N. Central Ave

19. 9-3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1946, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1944 to August 31 1946 and that I last saw her alive on August 31 1946

Immediate cause of death	DURATION
Chronic Hypocardiitis	Known to us since May 29 1944.
Due to:	
Due to:	
Other conditions: Senile Psychoses	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Hart J. Hildebrand M. D. or other

Address: ..... Date signed: .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25 — 07666

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs., 5 mos., 18 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 15 yrs., 5 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 788 Mulberry Street (If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: BLAKE - GEORGE

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
71	unknown		——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: George Blake
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Lucinda Snowden
MOTHER 15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug. 6, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Westport, Maryland
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St., Balto., Md.
19. 8/5 (Date rec'd by registrar) 19 46 A.W. Hedant Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 19 46 at 5:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 31 to August 2 19 46 and that I last saw him alive on August 2 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 2/14/31
Due to: ———	
Due to: ———	
Other conditions: ———	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Albert L. Anderson M. D. or other
Address: Crownsville, Maryland Date signed: 8/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete. Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

07667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years, 8 months 24 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 9 years, 8 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

(a) If veteran, name war:

3. (a) FULL NAME: BOULDIN ELIJAH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	bl.	widowed

6.(b) Name of husband or wife: unknown

7. Birth date of deceased (mo., day, yr.): 1878 6.(c) If alive, give age: years

8. AGE:

Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Bouldin Wilson

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Pierson Casanda

15. Birthplace: unknown

16. Informant: Hospital records

Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug-13-1946 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem

Location: Baltimore - Md.

18. Funeral director: Mrs Frances A. Sweeney

Address: 578 W. Fredk St

19. 8/11 - 46 E. F. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1946, at 7 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 16, 1936 to August 10, 1946 and that I last saw him alive on August 10, 1946

Immediate cause of death	DURATION
Generalized arteriosclerosis	since admission November 1936
Due to:	
Due to:	
Other conditions: Senile psychosis, cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Winstead, M. D. or other

Address: Crownsville Date signed: 8/11/1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

CERTIFICATE OF DEATH

P 07668 23

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co.
City or town Linthicum Hgts.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
Raynor Hgts.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Linthicum Hgts
(If outside city or town limits, write RURAL and give nearest town)
Street No. Raynor Hgts.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Elizabeth Virginia Boyer

3.(b) Social Security Number 214-03-7424

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Grover C. Boyer
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 7th, 1889

8. AGE: Years 57 | Months 5 | Days 23 | If less than one day .....hrs. .....min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Wm. H. Wade
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden name Elizabeth M. Wheeler
15. Birthplace A. A. Co., Md.

16. Informant Mr. G. C. Boyer
Address Linthicum Hgts., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1946 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

19. Funeral director W. J. Fickner & Sons.
Address Light & Pleasant Sts., Balto., Md.

9-3 46 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30th 46 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1st 46 to Aug. 30 1946
and that I last saw her alive on Aug. 29 46. 19.46

Immediate cause of death	DURATION
Abdominal & Pelvic Carcinomatosis	4 mos.
Due to Carcinoma of Ovary	9 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Ovary
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Shipley M.D.
M. D. or other
Address Savage, Md. Date signed 8/31/46

Evidence for change of year of birth of deceased is shown on FILM No. I 07 SEP 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

07669

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County a a

City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 109 Market Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Market Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Tarsaway Brewer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 13, ~~1867~~ 1867

8. AGE: Years	Months	Days	If less than one day
78	10	8	..... hrs. ..... min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation Retired Grocer

11. Industry or business

FATHER 12. Name Richard H. Brewer

13. Birthplace Annapolis, Md.

MOTHER 14. Maiden name W. Bacsford

15. Birthplace Md.

16. Informant Robert M. Brewer

Address 109 Market St.

17. Burial Date thereof 8-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's Cemetery

Location Annapolis, Md.

18. Funeral director John M. Layfield & Son

Address Annapolis, Md.

19 August 23 1946 Wm. D. Lynch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1946 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Aug 20 1946 and that I last saw him alive on Aug 20 1946

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	unknown
Due to	
Other conditions Hypertension	unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Boyd M. D. or other

Address Annapolis Md. Date signed 8-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C7670 Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years 2 months 4 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 years 2 months 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 926 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Octavous Butts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6.(b) Name of husband or wife: Flossie Butts
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 63 | Months: unknown | Days: | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Butler and chauffeur
11. Industry or business: unknown
FATHER 12. Name: Henry Butts
13. Birthplace: Va
MOTHER 14. Maiden name: Lavinia Parks
15. Birthplace: Md
16. Informant: Hospital Records
Address: Crownsville Md
17. Burial (Burial, cremation, or removal/ Which?) Date thereof Aug. 21, 1946 (month) (day) (year)
Cemetery or crematory: Western Stat Cemetery
Location: Baltimore Co. Md.
18. Funeral director: Mrs. George A. Holland
Address: 1631 Druid Hill Ave.
19. 8/21/46 (Date rec'd by registrar) Alice Ford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1946 at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1941, to August 18 1946
and that I last saw him alive on August 17 1946

Immediate cause of death	DURATION
General Paresis	Known
Due to	to us
	nuce
Due to	May 23
	1941
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John V. Sinkford M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07671

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four months
Hospital, Institution, or street address where death occurred: Army Area Regional Station Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? Three Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County
City or town Wilmerding
(If outside city or town limits, write RURAL and give nearest town)
Street No. 449 Welch Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ANNA R. CAHILL

3. (b) Social Security Number: 467-09 - 7905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: 1st Sgt. John J. Cahill
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 2 May 1916

8. AGE: Years	Months	Days	If less than one day
30	3	28	hrs. min.

9. Birthplace: Houston, Texas (Town, county, and state)
10. Usual occupation: Clerical work
11. Industry or business

FATHER
12. Name: Harry Gaffney
13. Birthplace: Houston, Texas

MOTHER
14. Maiden name: Eva Gaffney
15. Birthplace: Texas

16. Informant: Husband - 1st Sgt. John J. Cahill
Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 31 August 1946 (month) (day) (year)
Cemetery or crematory: Fort Sam Houston
Location: Texas
18. Funeral director: Oder Funeral Home Inc
Address: 4644 York Road, P.G. Hays.
19. 31 August, 1946 (Date rec'd by registrar) Conrad F. Kerwin BERNARD F. KERWIN, Capt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 August 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Aug 1946 to 30 Aug 1946 and that I last saw her alive on 29 Aug 1946.

Immediate cause of death: Undiagnosed Condition manifested by fever, leucocytosis, cerebral intoxication, Asthma, skin rash — DURATION
Due to: Probably due to Periarteritis Nodosa or disseminated lupus erythematosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Inflamed aortic Value. Ruptured Peptic ulcer
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Robert E. Eckardt Maj MC (M. D. or other)
Address: Regional Hospital FGGM Date signed: 23 Sept 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07672 23

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Rural Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Solley Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ANDREW CARPENSKI

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): July 15, 1906

8. AGE: Years	Months	Days	If less than one day
40			hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Welder
11. Industry or business: Shipbuilding

FATHER
12. Name: Frank Carpenski
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary Anuszewski
15. Birthplace: Poland

16. Informant: Mrs. Mary Carpenski
Address: Solley Road, Glen Burnie P.O., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 27, 1946 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Baltimore
16. Funeral director: M. J. Sadowski & Son
Address: 1908 Eastern Ave

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1946, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946, to Aug 15 1946, and that I last saw him alive on August 16 1946.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Sudden
Due to: Hypertension (Malignant) and Myocardial Insufficiency	Long Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Leon J. Hartley M.D. M. D. or other
Address: 4720 Pennington Ave Date signed: Aug 25 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07673

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ———

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1314 McCulloh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———— ✓

3.(a) FULL NAME: COLE - MARION

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Anna Cole, 1314 McCulloh St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
49	unknown		——— hrs. ——— min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Doorman

11. Industry or business: Theater

FATHER — 12. Name: Lester Cole

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Ada ?

MOTHER — 15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?) Date thereof Aug. 9, 1946 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial

Location: Arbutus, Maryland

18. Funeral director: Wm. A. Jackson

Address: 916 Pennsylvania Ave., Balto., Md.

19. Aug 7 1946 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 19 46 at 12:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 46 to August 6 19 46 and that I last saw him alive on August 6 19 46

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 7/29/46
Due to: ———	
Due to: ———	
Other conditions: Paranoid Condition	Known to us since 7/29/46

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert J. Bristow M. D. or other

Address: Crownsville, Maryland Date signed 8/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-1)

CERTIFICATE OF DEATH

07674

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 7 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 5 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ----

City or town: 648 George Street, Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3.(a) FULL NAME

COLORED - FANNY Gomage

3.(b) Social Security Number ----

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 186--? 187--?

8. AGE: Years	Months	Days	If less than one day
Between 70 and 80	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ----

FATHER
12. Name: James Woodward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Caroline Bryant ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-3-46 (month) (day) (year)

Cemetery or crematory: Mount Unknown

Location: Negro Lot

18. Funeral director: Mrs. K. R. Williams

Address: 3222 N. Charles St

19. 9-3 46 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946, to Aug. 29, 1946, and that I last saw her alive on August 29, 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 3/22/46
Due to: ----	
Due to: ----	
Other conditions: Senile Psychosis	Known to us since 3/22/46

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? (City or town) (County) (State) ----

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: Neil J. Whitehead M. D. or other

Address: Crownsville, Maryland Date signed: 8/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 07675 6

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 614 George Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: DOWNS - MARY MARGARET

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Nimrod Downs, 614 George St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE:

Years	Months	Days	If less than one day
57	unknown		------ hrs. ---- min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1946 (month) (day) (year)

Cemetery or crematory: ~~Mt. Auburn~~ Arbutus

Location: Baltimore arbutus memorial

18. Funeral director: Isiah Brown & Son
Address: 108 W. Montgomery St., Balto., Md.

19. Aug 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 19 46 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 19 46 to August 23 19 46 and that I last saw her alive on August 23 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 8/10/46
Due to: ------	
Due to: ------	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 8/10/46

Major findings of operations: ------ Date of op. ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury ------ Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 8/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07676

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pines on the Severn
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William S. Duggins Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 2nd 1936

8. AGE: Years: 9 | Months: 8 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Winson Salem N.C.
(Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER
12. Name: Wm S. Duggins Sr.
13. Birthplace: Winson Salem N.C.

MOTHER
14. Maiden name: Thelma Tirey
15. Birthplace: Roanoke Va.

16. Informant: Wm S. Duggins Sr.
Address: Pines on the Severn Arnold Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 14th 1946 (month) (day) (year)
Cemetery or crematory: Asbury Churchyard
Location: Arnold Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.

19. August 13 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12 19 46, at 1 15 P.M.

21. I CERTIFY that death occurred on the date above (state): ~~that decedent deceased from~~
Post Mortem Examination Findings
~~at that last saw him alive on~~ Aug. 12 19 46

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8/12/46
Where did injury occur? Pines-on-Severn (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Chase Creek
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. of other
Address: Annapolis Md Date signed: 8/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

07677

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 N. Southwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie L. Dunn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Elbert Dunn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16th 1876

8. AGE: Years 70 | Months 3 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation Retired Government Employee

11. Industry or business

FATHER
12. Name William M. Bealer
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Ellen Elizabeth Hopkins
15. Birthplace Annapolis Md.

16. Informant Francis E. Engle
Address 6 N. Southwood Ave Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27th 1946 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18. Funeral director John M. Taylor, Son
Address Annapolis Md.

19. August 27 19 46 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 46 at 4:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 40 to Aug 25 19 46 and that I last saw her alive on Aug 25 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Coronary Sclerosis	2 yrs.
Due to	
Other conditions Hypertension	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE George C. Bond M. D. or other
Address Annapolis Md Date signed 8. X. 46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

67078

Reg. Dist. No. 2I

1. PLACE OF DEATH:
County Anne Arundel
City or town Marley Neck
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since birth
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Marley Neck
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES OLIVER EDWARDS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? ?

8. AGE: Years	Months	Days	If less than one day
over 70			hrs. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual occupation farm hand
11. Industry or business

FATHER
12. Name George Edwards
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden name Elizabeth ?
15. Birthplace A. A. Co. Md.

16. Informant Samuel Otis Edwards
Address P. O. Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-19-46 (month) (day) (year)
Cemetery or crematory Marley Neck Cem.
Location Marley Neck, A. A. Co., Md.

18. Funeral director Isiah Brown and Son
Address 108 W. Mongomery st.

19. 8-17 1946 L. A. Breit Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to Aug. 17 1946 and that I last saw him alive on August 13 1946

	DURATION
Immediate cause of death: Cerebral hæmorrhage	4 days
Due to: Arteriosclerosis	? years
Due to:	
Other conditions: Arteriosclerotic heart (compensated past 6 weeks)	disease

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. A. Breit, M. D.
M. D. or C.M.
Address Tasneum Md. Date signed 8-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(186a)

CERTIFICATE OF DEATH

07679

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A., Co.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mountain Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: KENNETH R. FOWLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 31, 1944

8. AGE: Years	Months	Days	If less than one day
2	7	0	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Child
11. Industry or business

FATHER
12. Name: Frank Lee Fowler
13. Birthplace: Calvert Co., Md.

MOTHER
14. Maiden name: Mildred A. Michael
15. Birthplace: Baltimore, Md.

16. Informant: Frank Lee Fowler (Father)
Address: Mountain Rd., Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial Cem.
Location: Annapolis Rd., A.A Co. Md.

18. Funeral director: Charles S. Feiler.
Address: 3605 Fait Ave., Balto., Md.

19. 9-3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1946, at 6 25 p. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination
~~and that I last saw h~~ alive on 19

Immediate cause of death	DURATION
Fracture of neck	
Due to Sudden snap of head during a	
Due to fall in back yard	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 8-31-46
Where did injury occur? Pasadena (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) at home in back yard
Means of injury Fall out of Trailer Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy medical Examiner
M. D. or other
Address: Annapolis Maryland Date signed: 8-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 67680

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a a.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: maryland County: a a

City or town: Jones Station

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pitchie Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: anna margaret Fot

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	widow

6.(b) Name of husband or wife: Geo F Fot

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 26 - 1866

8. AGE:	Years	Months	Days	If less than one day
	80	5	18	..... hrs. ..... min.

9. Birthplace: Balto. md (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER 12. Name: John Cook

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: mary Heshmer

MOTHER 15. Birthplace: Germany

16. Informant: Carlton W Fot

Address: annapolis R.F.D. 3 Box 30

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 - 46 (month) (day) (year)

Cemetery or crematory: Calvary Hill

Location: Pitchie Highway

18. Funeral director: B. I. Hopping

Address: annapolis, md

19. August 15 19 46 (Date rec'd by registrar) W. Dorsch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1946 at 3.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1946, to Aug 13 1946 and that I last saw h[illegible] alive on Aug 12 1946

Immediate cause of death	DURATION
Pulmonary edema	3 days
Due to: Ac. Cardiac Dilatation	3 days
Due to: Coronary Thrombosis	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Klasmann Md M. D. or other

Address: 31 Southgate ave Date signed 8/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

07681

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Kentucky County: Adair Co., Ky.
City or town: Gadberry, Kentucky
(If outside city or town limits, write RURAL and give nearest towo)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Burel Hogard FRANKUM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1924

8. AGE:

Years	Months	Days	If less than one day
22	02	06	hrs. min.

9. Birthplace: Gadberry, Kentucky
(Towo, county, and state)

10. Usual occupation: Seaman

11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace: Unknown

MOTHER 14. Maiden name: Mary Frankum
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Annapolis Md

17. Burial, cremation, or removal. Which?: Removal
Date thereof: aug 10/46 (month) (day) (year)
Cemetery or crematory: Unknown
Location: Gadberry Kentucky

18. Funeral director: B. L. Hopkins & Son
Address: Annapolis Md.

19. Aug 10 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1946, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Dead on arrival 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Intracranial injury	Dead on arrival
Due to: Gunshot wound of the head	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation: No operation
Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: Aug. 7, 1946
Where did injury occur? Annapolis (City or towo), Anne Arundel (County), Md. (State)
Injured at home, farm, industry, public place (where?): U.S.S. Reina Mercedes
Means of injury: Gunshot wound Injured at work? yes

23. SIGNATURE: John P. Williams Jr. M.D.
M. D. or other
Address: U.S. Naval Hospital, Annapolis, Md.
Date signed: Aug. 10, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27 — 7682

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred: Army Area Regional Station Hospital, Ft. Geo. G. Meade, /Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: NONE
(For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No., (If rural, give LOCATION)

2.(a) If veteran, name war: World War #1 Veteran

3.(a) FULL NAME: NATHAN GLICKERMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 24, 1888

8. AGE: Years	Months	Days	If less than one day
57	7	8	hrs. min.

9. Birthplace: Chnstochowa, Poland (Town, county, and state)

10. Usual occupation: No particular occupation

11. Industry or business: None

FATHER — 12. Name: Max Glickerman

13. Birthplace: Chnstochowa, POLAND

MOTHER — 14. Maiden name: Gndel Gndelman Glickerman

15. Birthplace: Chnstochowa, POLAND

18. Informant: J. I. Glickerman (Brother)

Address: 154 W. Division St., Chicago, Illinois

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 3 1946 (month) (day) (year)

Cemetery or crematory: Chicago, Illinois

Location:

18. Funeral director: J. S. Chambers Co

Address: 5801 Cleveland Ave. Riverdale, Md

19. 2 August, 1946 (Date rec'd by registrar) V. B. TAYLOR, Capt., MAC, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 2 1946, at 10:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 July, 1946, to 2 August, 1946 and that I last saw him alive on August 2, 1946

Immediate cause of death	DURATION
Probably cerebric-vascular accident,	
secondary to coronary occlusion	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hugh H. Wells 1/Lt (M. D. or other)

HUGH H. WELLS, 1st Lt., M.C.

Address: Reg. Hosp., Ft. G. G. Meade, Md. Date signed:

I. H. S.

Ofo. Usual Reo.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170©)

CERTIFICATE OF DEATH

07683

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Defence Highway (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: District of Columbia
City or town: Washington D.C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 1780 Mass Ave. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LEON F. GRELL
3.(b) Social Security Number

4. Sex: MALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: MARRIED
6.(b) Name of husband or wife: SIMONE GRELL
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): MAY 9th 1903

8. AGE: Years	Months	Days	If less than one day
43	3	1	... hrs. ... min.

9. Birthplace: ANTIVERP BELGIUM (Town, county, and state)
10. Usual occupation: BELGIUM ECONOMIC MISSION
11. Industry or business

FATHER
12. Name: JOHN GRELL
13. Birthplace: ANTIWERP BELGIUM

MOTHER
14. Maiden name: GABRIELLE PEETERS
15. Birthplace: ANTIWERP BELCIUM

16. Informant: WILLIAM F. GRELL
Address: P.O Box 42 NEW MILFORD CONN.
17. TEMPORARY VAULT (Burial, cremation, or removal. Which?) Date thereof: AUG 13th 1946 (month) (day) (year)
Cemetery or crematory: FORT LINCOLN
Location: WASHANGTON D.C.
18. Funeral director: JOHN M. TAYLOR & SON
Address: ANNAPOLIS Md.
19 August 12 1946 (Date recd by registrar) Wm. D. French, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1946, at 10:00 A.M.
21. I CERTIFY that death occurred on the date above stated; Postmortem Examination Aug. 10, 1946

Immediate cause of death	DURATION
Crushed skull	sudden
Due to: Hemorrhage	sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/10/46
Where did injury occur? Route #50 (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Route 50, 9½ miles west of Annapolis
Means of injury: Auto-wreck Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M.D. or other)
Address: Annapolis, Md. Date signed: 8/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

07684

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

1. PLACE OF DEATH:

County. A. A. County

City or town. Galesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. Md. County. A. A. Co.

City or town. Galesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Quaker's burial ground
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emily Turner Gross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col-	Married

6.(b) Name of husband or wife. John F Gross

6.(c) If alive, give age. 60 years

7. Birth date of deceased (mo., dsy, yr.) 1893 - June 30th

8. AGE:

Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace. Galesville A A Co Md
(Town, county, and state)

10. Usual occupation. Domestic

11. Industry or business. Home

FATHER
12. Name. Edward Turner
13. Birthplace. Galesville A A Co Md

MOTHER
14. Maiden name. Susanna Smith
15. Birthplace. Galesville A A Co Md.

16. Informant. Jerome Turner
Address. Galesville A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof. August 22 1946 (month) (day) (year)

Cemetery or crematory. Daniel Stansbury Cem.

Location. Galesville A A Co.

18. Funeral director. T. A. Hardesty & Son

Address. Galesville A A Co Md.

19. Aug 20 46 (Date rec'd by registrar) 19.. H. K. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH. August 20, 1946, at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1940, to Aug 20 1946, and that I last saw her alive on Aug 19 1946

Immediate cause of death. Myocarditis Chronic — DURATION 6 yrs

Due to.

Due to.

Other conditions. Def. Arteriosclerosis Chronic — ?

Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operation. Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE. F C Test M.D.
M. D. or other

Address. Lothian Md. Date signed 8/20/46.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-C

CERTIFICATE OF DEATH

Reg. Dist. No. 07685

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ***********

Hospital, institution, or street address where death occurred: Drop at B & A. Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Neck (If outside city or town limits, write RURAL and give nearest town)

Street No.: Annapolis Neck Nr Annapolis (If rural, give LOCATION)

2.(a) If veteran, name war: **************

3. (a) FULL NAME: Lillian Gross

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph Gross

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): August 24, 1893

8. AGE: Years: 52 Months: Days: If less than one day ...... hrs. ...... min.

9. Birthplace: Washington D. C. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: None

FATHER

12. Name: Jordan Williams

13. Birthplace: Dover Delaware

MOTHER

14. Maiden name: Annie Hayes

15. Birthplace: Dover Deleware

16. Informant: Joseph Gross

Address: Annapolis Neck Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 12, 1946 (month) (day) (year)

Cemetery or crematory: Annapolis Neck Cemetery

Location: Annapolis Neck

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. August 12 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 9, 1946. 6.30 M

21. I CERTIFY that death occurred on the date above stated; [redacted]

POSTMORTEM EXAMINATION 19 19

[redacted] Aug. 9, 1946 19

Immediate cause of death: Acute Dilatation of Heart DURATION: sudden

Due to: Obesity

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis Md Date signed: 8/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

CERTIFICATE OF DEATH

★ 07686 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Brookfield, Pasadena P.O. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Fairfax
City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 76, Route #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Lawrence Hanson

3.(b) Social Security Number: 435-28-4257

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Alta M. Hanson
Davenport
6.(c) If alive, give age: 37 years
7. Birth date of deceased (mo., day, yr.): August 8, 1900

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
46	0	3		

9. Birthplace: Duluth Minn.
(Town, county, and state)
10. Usual occupation: Carpenter -
11. Industry or business:

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN

16. Informant: Mrs. Alta Hanson
Address: 207 Fifth St. Augusta, Ga.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven Cemetery
Location: Glen, Bowie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. Aug 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1946, at 2 47 P.M

21. I CERTIFY that death occurred on the date above stated; the [redacted] Postmortem Examination, [redacted] Aug. 11, 1946

Immediate cause of death	DURATION
Electrocution	
Due to: 2200 Volt Contact	Sudden
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/11/46
Where did injury occur? Brookfield, Pasadena, A.A., Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Cook's Place at Brookfield
Means of injury: 2200 Volts electricity Injured at work? yes

23. SIGNATURE: John M. Cleary, M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Maryland Date signed: 8/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07687

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs, 4 mos, 23 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 8 yrs, 4 mos, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 894 Tyson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME

HARRIS - ELIZABETH

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widowed

6.(b) Name of husband or wife: Freeman Harris

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years	Months	Days	If less than one day
35	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER 12. Name: Thomas Thomas

13. Birthplace: unknown

MOTHER 14. Maiden name: Minnie Hammond

15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Mrs. S. T. Hemsley

Address: 578 W. Biddle St., Balto., Md.

19. Aug 8 1946 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1946, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1938 to August 7 1946 and that I last saw her alive on August 7 1946

Immediate cause of death: General Paresis — DURATION: Known to us since 3/14/38

Due to: ----

Due to: ----

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings of operation: ---- Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 8/7/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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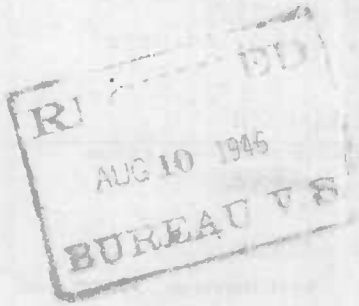
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Highpoint
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Highpoint
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riverside Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Franklin Harvey

3.(b) Social Security Number: 218-03-3858.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1884

8. AGE: Years 62 63 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Seaman.

11. Industry or business: -

FATHER
12. Name: Lewis Harvey
13. Birthplace: Salisbury Md.

MOTHER
14. Maiden name: Emelia Jaffia
15. Birthplace: St. Mary's County

16. Informant: William Harvey (Brother)
Address: 660 E. Robinson St. Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-31-47. (month) (day) (year)
Cemetery or crematory: Mt. Carmel Cem.
Location: O'Donnell St; Balto. Md.

18. Funeral director: Charles S. Zeiler
Address: 901 S. Conkling St.

19. Oct 31 19 47 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~September~~ (Aug) 46 19 at M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination
~~and that I last saw him alive on~~ 19

Immediate cause of death	DURATION
Suicide by hanging	
Due to:	
Other conditions	

Funeral director states body found hanging in condition indicating death in 1946 about Aug. Home, long untouched, contained table with decayed food thereon; calendars and mail indicated August 1946. Residents had noted foul odor in neighborhood for some time.

(Include pregnancy within 3 months of death) 10/31/47 LL

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: unknown
Where did injury occur? Highpoint (City or town) A. A. (County) Md (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: hanging by rope Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Maryland Date signed: 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

07688

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs, 11 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 27 yrs, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Trappe
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME: HAYWARD - ANNIE R.

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years	Months	Days	If less than one day
50	unknown		---- hrs. ----- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------

FATHER
12. Name: James Hayward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Leah Mills
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-9-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt.
Address: Crownsville, Md.

19. Filed Aug 9 1946 E. F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 19 46 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 19 19 to August 2 19 46 and that I last saw her alive on August 2 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	One day
Due to: -------	
Due to: -------	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	Known to us since 7/21/19

Major findings of operations: --------
Date of op.: -------
Autopsy results: --------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Hook J. Pinkerton M. D. or other
Address: Crownsville, Maryland Date signed 8/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

07689

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 477 Greenwood Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John H. Heid.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Marie A. Heid
Nee Huber
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): October 22, 1895

8. AGE: Years	Months	Days	If less than one day
50	10	1	hrs. min.

9. Birthplace: Baltimore
(Town, county, and state)
10. Usual occupation: R.F.D Carrier
11. Industry or business: U.S. Post Office Dept.

FATHER
12. Name: Frank Heid
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Josephine Sanders
15. Birthplace: Baltimore Md

16. Informant: Mrs. Marie Heid
Address: Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26, 1946 (month) (day) (year)
Cemetery or crematory: Louden Park
Location: Baltimore, Md
18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md.

19. Aug 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1946, to Aug 23 1946
and that I last saw him alive on Aug 23 1946

Immediate cause of death	DURATION
Cardio Vascular Disease	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas L. Bare Jr M.D.
M. D. or other
Address: Linthicum Date signed: 8-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

★ 17690 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Skidmore Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Skidmore near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Samuel Henson

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: None 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE:

Years	Months	Days	If less than one day
71	8	10	..... hrs. ..... min.

9. Birthplace: Skidmore near Annapolis (Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business

FATHER
12. Name: Charles Henson
13. Birthplace: Skidmore near Annapolis

MOTHER
14. Maiden name: Mary Thomas
15. Birthplace: Skidmore near Annapolis

16. Informant: Herman Colbert
Address: Skidmore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 22 (day) 1946 (year)
Cemetery or crematory: Broad Neck
Location: Skidmore

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. August 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1946 at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1946 to August 17 1946
and that I last saw h[illegible] alive on Aug 17, 1946

Immediate cause of death: Acute dilatation of the Heart — DURATION: Instant.
Due to: .....
Due to: .....
Other conditions: Arteriosclerotic - Cardio - Vascular Disease
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gilbert R. Gudebrod M.D. M. D. or other
Address: Annapolis, Md. Date signed 8/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

07691 212
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 days
Hospital, institution, or street address where death occurred:
Md. House of Correction
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Edward Holmes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col'd	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Not known

8. AGE: Years	Months	Days	If less than one day
56			..... hrs. ..... min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: U nknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: None
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7 1946 (month) (day) (year)
Cemetery or crematory: Cherry Hill.
Location: Jessups, Md.
18. Funeral director: Harry L. Collins
Address: Jessups md
19. Sept 7 (Date rec'd by registrar) 19 46 Clara Kasleh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 5:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1946 to August 29 1946 and that I last saw h... im alive on August 29 1946

Immediate cause of death: Congestive heart failure & edema of the lungs. — DURATION: one day

Due to: Aortic & mitral insufficiency.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Clark M.D.
M. D. or other
Address: Maryland House of Corr. Date signed: 8/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07692 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2466 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EDWARD ~~HOWARD~~ COLEMAN Howard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Josephine
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 20, 1922

8. AGE: Years	Months	Days	If less than one day
24	--	--	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Garage attendant
11. Industry or business:

FATHER
12. Name: Linwood Howard
13. Birthplace: Charlottesville, Va.

MOTHER
14. Maiden name: Marion Wicks
15. Birthplace: Queen Anne Co. Md.

16. Informant: Josephine Howard
Address: 2466 Druid Hill Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1946 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Pk.
Location: Baltimore Co. Md.

18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave.

19. 9-3 46 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1946, at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
accidental burns	Sudden
Due to: Automobile accident	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8/30/46
Where did injury occur? Millersville (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: Linwood H. Farber M.D.
Address: Acting Medical Examiner, Glen Burnie Md. M.D. or other
Date signed: 9/2/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

07693

CERTIFICATE OF DEATH

Reg. Dist. No. 2 5

1. PLACE OF DEATH:
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Maple & States Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maple & States Road
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Mrs. Ada C. Hughes

3. (b) Social Security Number none

4. Sex F.
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife X Charles
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) June 12 - 1880

8. AGE: Years 66 Months 2 Days 19 If less than one day ...... hrs. ...... min.

9. Birthplace Alexandria, Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Matron at Rosewood Training School.

FATHER
12. Name Thomas H Coakley
13. Birthplace Virginia

MOTHER
14. Maiden name Mary Stone
15. Birthplace Washington, D. C.

16. Informant Mrs. F. Covington
Address Severna Park, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 2. 1946 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md
18. Funeral director Wilhelm Co. Inc
Address 1207 St Paul St

19 Aug 31 1946 (Date rec'd by registrar) M B De Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1946, to Aug. 31 1946
and that I last saw her alive on Aug. 30 1946

Immediate cause of death Cerebral Hemorrhage — DURATION 12 hrs.
Due to Hypertension — DURATION ?
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Parker M.D. M. D. or other
Address Glen Burnie Md. Date signed 8/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67694 P

Reg. Dist. No. 22

M

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural, Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Michael Jablonski

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Jablonski
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: For Self

FATHER
12. Name: Jacob Jablonski
13. Birthplace: Poland

MOTHER
14. Maiden name: Julia Szczelczyk
15. Birthplace: Poland

16. Informant: Mary Jablonski
Address: Box 49 Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3 '46 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Baltimore
18. Funeral director: Fred W. Ozazewski
Address: 1930 Eastern Ave.
19. 9/2 1946 A.W. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1946, to Aug 29 1946
and that I last saw h.. alive on Aug 29, 1946

	DURATION
Immediate cause of death: Coronary Occlusion	24 hrs
Due to: Hypertension,	8 mo
Due to: Arterio Sclerosis	2 yr
	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: O. Hoffman M.D. M. D. or other
Address: Millersville Md. Date signed: 8/31/46

07695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County Anne Arundel
City or town Columbia Beach Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 927 - P. St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ambrose R. Johnson

3. (b) Social Security Number ~~225-28-4257~~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1896

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace Washington. D. C.
(Town, county, and state)
10. Usual occupation Messenger
11. Industry or business Veterans Bureau
FATHER 12. Name Henry Johnson
13. Birthplace Virginia.
MOTHER 14. Maiden name Lucy
15. Birthplace Maryland
16. Informant Mrs Johnson.
Address 1019 Fairmont St. N.W. Wash D.C.
17. Removal Date thereof August 14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Washington D. C.
Location Washington D. C.
18. Funeral director Mrs Charles E. Hicks
Address 45 Northwest St. Annapolis Md.
19. August 12 19 46 J. B. Dent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1946 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated [illegible]
Postmortem Examination
[illegible] Aug. 11 1946

Immediate cause of death	DURATION
Coronary Embolism	Sudden
Due to	
Coronary Sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Cathy M.D. Deputy Medical Examiner
M.D. or other
Address Annapolis Md Date signed 8/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

07696

CERTIFICATE OF DEATH

★ Reg. Dist. No. 23

1. PLACE OF DEATH:
County: A. A. Co. Md
City or town: Cedar Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mths
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A
City or town: Cedar Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cedar Hill Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Annie D. Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE:

Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace: Burgaw. N. C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Wm. Murphy
13. Birthplace: N. C.

MOTHER
14. Maiden name: Mattie
15. Birthplace: N. C.

16. Informant: Charles Jones
Address: 601 N. Fremont ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6-46 (month) (day) (year)
Cemetery or crematory: Burgaw. N. C.
Location:

18. Funeral director: James A Stacys
Address: 142 Wolfe St

19. Aug 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1946, to Aug 2 1946
and that I last saw h.er alive on Aug 2 1946

	DURATION
Immediate cause of death: Carcinoma of (Stomach)	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jas L. Julian M. D.
M. D. or other
Address: 516 N. Schroder St. Date signed: 8/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2d)

07697

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Emergency Hospt.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Maryland County: A A

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Margaret Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward B. Jones

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 18th 1869

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Davidsonville Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Williams Purdy

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rathbourn

15. Birthplace: Rathbourn

16. Informant: Mrs Raymond Garner

Address: 168 Cypress St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26th 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: Jos. M. Taylor. Son

Address: Annapolis Md.

19. August 23, 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1946, at 1630 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to Aug 22 1946

and that I last saw her alive on Aug 22, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hr
Due to: Hypertension C.V. disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E Rumbaugh M. D. or other

Address: Easton, Md. Date signed: 8/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07698

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Raynor Heights, P.O. Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About one day.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: A. A.
City or town: Fork Union
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ?
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Howard Kane

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1929

8. AGE: Years: 17 Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: New Jersey
(Town, county, and state)

10. Usual occupation: Pupil

11. Industry or business

FATHER
12. Name: William Thomas Kane
13. Birthplace: ? —

MOTHER
14. Maiden name: Bessie D. Wilbes
15. Birthplace: Virginia —

16. Informant: William B. Green (Stepfather)
Address: Patapsco Park – Baltimore 25

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 12-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: Brooklyn Md.

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley Ave

19. Aug 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7th 1946 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Accidental Drowning	Sudden
Due to: Found in the A. A. Corporation Ditch – Ft Meade Road – Raynor Heights.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8/7/46
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Gustave A. Gaudreau M.D.
acting medical examiner M. D. or other
Address: Glen Burnie Md. Date signed 8/9/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (188)

CERTIFICATE OF DEATH

07699

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:
Annapolis Emergency Hospital

How long in hospital or institution? 9 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Crownsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Harry Frazier Klein

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Rachel R. Klein

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1892

8. AGE: Years	Months	Days	If less than one day
53	8	0	...hrs. ...min.

9. Birthplace: Anneville, Lebanon, Pa.
(Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business

FATHER 12. Name: Luther Ross Klein

FATHER 13. Birthplace: Harris Lebanon, Pa.

MOTHER 14. Maiden name: Cora Maulflair

MOTHER 15. Birthplace: Anneville, Pa.

16. Informant: Rachel R. Klein

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7th 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Altoona, Pennsylvania

18. Funeral director: John M. Taylor & Son

Address: Annapolis - Md

19. Aug. 6, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5 19 46 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ ... 19... to ... 19...

and that I last saw it ... alive on ... 19...

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Crushing injury of chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Aug. 4, 1946

Where did injury occur? Crownsville (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Farm

Means of injury: Crushed by bull Injured at work? Yes

23. SIGNATURE: Edward P. Ritelinger, M.D.
M. D. or other

Address: 199 Gloucester St. Annapolis, Md. Date signed: Aug. 5, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

07700

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Brooklyn P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7-3rd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Martha E Kneicker

3. (b) Social Security Number: No

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Andrew Kneicker
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 13, 1866
8. AGE: Years: 80 Months: 3 Days: 2 If less than one day: hrs. min.
9. Birthplace: Pittsburg Pa. (Town, county, and state)
10. Usual occupation: at home
11. Industry or business:
FATHER 12. Name: Robert Powell
13. Birthplace: Balto Md
MOTHER 14. Maiden name: Sarah Brown
15. Birthplace: Balto Md
16. Informant: Mrs Earl Brenta Daughter
Address: 7-3rd Ave Brooklyn P.O.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A a 66
18. Funeral director: A Howard E Evans
Address: 1400 S Charles St
19. August 15 1946 (Date rec'd by registrar) Ida M Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15, 1946, at 1220a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 11, 1946, to aug 15, 1946 and that I last saw h.e alive on aug 15, 1946

	DURATION
Immediate cause of death: Cardiac failure	
Due to: Hypertensive C-V disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James N Cairns, M. D. or other
Address: 302 Peterson Ave. Date signed: 16 Aug 46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

07701

P

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 7 mos, 18 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 yrs, 7 mos, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 546 Wilson Street (If rural, give LOCATION) ✓

2.(a) If veteran, name war: -----

3. (a) FULL NAME: KNIGHT - CORA

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife: Gillian Knight, 1213 E. Biddle St., Baltimore 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
46	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER — 12. Name: John Bundy

13. Birthplace: Richmond, Virginia

MOTHER — 14. Maiden name: Marie Gross

15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 27, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location:

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantly ave.

19. 8/23 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1946, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1944, to Aug. 21, 1946 and that I last saw her alive on August 21, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage - Right Hemiplegia	4 days
Due to: -----	
Due to: -----	
Other conditions: Hypertensive Heart Disease - Chronic Alcoholism (Include pregnancy within 3 months of death)	Known to us since 1/3/44

Major findings of operations: ------- Date of op. -------

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of: -----

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: ------- Injured at work? -----

23. SIGNATURE: [illegible] M. D. or other

Address: Crownsville, Maryland Date signed: 8/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06689

Reg. Dist. No. 20

1. PLACE OF DEATH:

County ANNE-ARUNDEL

City or town Edgewater Beach, Edgewater, RURAL ANNAPOLIS.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
Edgewater Beach, Edgewater.

How long in hospital or institution? ——

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County

City or town Fredericksburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME LOULA BROCKENBROUGH KNOX

3. (b) Social Security Number ——

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	Widowed

6.(b) Name of husband ~~or wife~~ DOUGLAS HAMILTON KNOX

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1866

8. AGE: Years	Months	Days	If less than one day
80		28	17 hrs. min.

9. Birthplace Richmond County, Virginia
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business NONE

FATHER 12. Name WILLIAM AUSTIN BROCKENBROUGH

FATHER 13. Birthplace Folly Farms, Richmond Co., Va.

MOTHER 14. Maiden name LUCY BEADLES

MOTHER 15. Birthplace Orange C.H., Va.

16. Informant Col. Louis E. Marié, USMC

Address Edgewater Beach, Edgewater, Md.

17. Removal Date thereof Aug 27th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Fredericksburg Va.

18. Funeral director Wheeler & Thompson

Address Fredericksburg Va.

19. August 27 19 46 J. Edward Collins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26th 1946, at 4:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 to Aug 26 1946 and that I last saw her alive on Aug 25 1946

Immediate cause of death Myocarditis & Myocardial Insufficiency — DURATION several years

Due to

Due to

Other conditions Arteriosclerosis — DURATION unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Bouil
M. D. or other

Address Annapolis Md. Date signed 8-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

07702

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Mayo
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1524 Potomac Ave. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Kosinski

3.(b) Social Security Number: 321-09-8705

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Harriet Kosinski

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1898

8. AGE: Years: 47 Months: 11 Days: 6 If less than one day: hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Tool Maker

11. Industry or business:

FATHER
12. Name: Carl Kosinski
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary Barycz
15. Birthplace: Poland

16. Informant: Harriett Kosinski

Address: 1524 Potomac St S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1946 (month) (day) (year)

Cemetery or crematory:

Location: Chicago Ill

18. Funeral director: D.C. Daugherty & Son

Address: Galesville Md.

19. Aug 5 1946 (Date rec'd by registrar) Edward Collenson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 Aug. 1946 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~1946~~ to 1946

and that I last saw him alive on 1946

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Asphyxiation	
Due to: Drowning	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 4 Aug 46

Where did injury occur? Rural - Mayo (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public Beach

Means of injury: Drowning Injured at work?

23. SIGNATURE: Edward P. Ritchings M.D.
M. D. or other

Address: 139 Gloucester St. Date signed: Aug. M.E. 4 Aug. 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

07703

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, Institution, or street address where death occurred: Army Area Regional Station Hosp., Fort Geo. G. Meade, Md.

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1229 Mc Cullough Street (If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: BERNEL M. LAWSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	SINGLE

8.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 February, 1924

8. AGE:	Years	Months	Days	If less than one day
	22	7	-	hrs. min.

9. Birthplace: Summerton, South Carolina (Town, county, and state)

10. Usual occupation: Steel Worker

11. Industry or business: Sparrows Point, Maryland

FATHER 12. Name: Bernel Lawson

13. Birthplace: Summerton, S.C.

MOTHER 14. Maiden name: Louise Martin

15. Birthplace: Summerton, South Carolina

16. Informant: Louise Martin (Mother)

Address: 1229 McCullough Street, Baltimore, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 31 August, 1946 (month) (day) (year)

Cemetery or crematory: Summerton, South Carolina

Location: (Summerton) Sumter S. C.

18. Funeral director: Mrs Katie R Williams

Address: 822 N. Schroeder St Baltimore, Maryland

19. 31 August 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 August, 1946, at 0850A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Aug 1946, to 31 Aug 1946 and that I last saw him alive on 31 Aug 1946

Immediate cause of death	DURATION
Shock, secondary to 80% burn	
Due to 80% Burn incurred in automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 30 Aug. 1946

Where did injury occur? Near Baltimore, Maryland (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): Public Road

Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: Howard Baxter 1st Lt. M.C. M. D. or other

Address: F. G. Meade, Md. Date signed: 9 Sept 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07704

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 10 mos., 18 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr., 10 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1615 Riggs Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: LYLES - WILLIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Lillian Lyles, 1615 Riggs Ave, Baltimore, Maryland 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): December 13, 1901

8. AGE: Years	Months	Days	If less than one day
44	8	6	---- hrs. ---- min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER — 12. Name: Thomas Lyles
13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Bergan Hugs
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Buried — Date thereof: Aug. 23, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Greensboro, North Carolina

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder St., Balto., Md.

19. 8/21 1946 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 44, to August 19 19 46 and that I last saw him alive on August 19 19 46

Immediate cause of death: Lung Tuberculosis — DURATION: Known to us since 4/22/46

Due to: ------

Due to: ------

Other conditions: Post-traumatic Psychosis — Known to us since 10/1/44
(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: -----

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? ------

23. SIGNATURE: Hobart J. Prindle M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 8/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07705

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: near Severna Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: near Severna Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES HENRY MANTLEY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widower

6.(b) Name of husband or wife: Lizzie Mantley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1879

8. AGE:	Years	Months	Days	If less than one day
	66	7	24	..... hrs. ..... min.

9. Birthplace: Mathews Co. Va.
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER — 12. Name: John Mantley

FATHER — 13. Birthplace: Matthews Co. Va.

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: " "

16. Informant: Mary B. Ashcraft

Address: 1010 Brantley ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-8-46 (month) (day) (year)

Cemetery or crematory: Brew Hill Cem.

Location: Annapolis, Md.

18. Funeral director: Jos. A. Lively

Address: 661 W. Berre st., Balto., Md.

19. 8-4 19 46 L. A. Blair Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 19 46 at 7.55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 44 to 8-4-46 19

and that I last saw h im alive on July 15-46 19

Immediate cause of death	DURATION
Cerebral hamorrhage	6 mos.
Due to: Arteriosclerosis	indefin.
Due to:	
Other conditions: Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. A. Blair M. D.
M. D. or other

Address: Pasadena Md. Date signed 8-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(158)

07706

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lindenwood Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Lindenwood Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 307 - N. Camp meade Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Irene Marsh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

8.(b) Name of husband or wife: Alydia Marsh
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 8 - 1946

8. AGE: Years | Months 7 | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ? Balto Md

MOTHER
14. Maiden name: ? Alydia Marsh
15. Birthplace: ? Chesterstown Md

16. Informant: Mrs. Linda Longwood
Address: 307 - N. Camp meade Rd. - Linthicum
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/46 (month) (day) (year)
Cemetery or crematory: Maryland Memorial Park
Location: Taylor ave
18. Funeral director: David R. Martin
Address: Manchester Md
19. Aug. 10 1946 (Date rec'd by registrar) A. A. Hebrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 1946 at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Heart Failure	Sudden.
Due to: Chronical Debility	Since birth
Due to: Anemia.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Faubert M. D.
Address: Glen Burnie, Md. Date signed 8/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-A)

07707

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour 35 minutes
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1634 B. St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME William H. Maurer, Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 1895

8. AGE: Years 48 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Taxi-driver

11. Industry or business: Diamond Cab Co.

FATHER
12. Name: William F. Maurer
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Anna May Fauser
15. Birthplace: Pennsylvania

16. Informant: William H. Maurer Jr.
Address: 1634 B St, N.E. Wash. D.C.

17. Buried — Date thereof: Aug 11-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington D.C.

18. Funeral director: Albert Pike
Address: 641 H St NE Wash D.C.

19. Aug 11, 19 46 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1946, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post mortem Examination ~~[illegible]~~ Aug. 11, 1946

Immediate cause of death	DURATION
Coronary occlusion	2 hours
Due to: Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 8/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

Reg. Dist. No. 07708 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Harwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Harwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: William McGhee (McGhee)

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife: Mary McGhee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ~~Unknown~~ May 2 1917

8. AGE:

Years	Months	Days	If less than one day
29	2	2	..... hrs. ..... min.

9. Birthplace: Halifax, Va.

(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business:

FATHER — 12. Name: Hamlit Mc Ghee

13. Birthplace: Halifax Co Va

MOTHER — 14. Maiden name: Lottie Mc. Ghee

15. Birthplace: Halifax Va.

16. Informant: John McGhee McGhee

Address: Glen Bernie

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1946 (month) (day) (year)

Cemetery or crematory: White Oak Lawn

Location: Halifax Co Va.

18. Funeral director: J. G. Hardesty & Son

Address: Galesville Md.

19. Aug 6 1946 (Date rec'd by registrar) Edward Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1946 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.. to ..... 19..

and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Gunshot wound chest,	
anterior, 3rd interspace,	
Due to 1 inch left of midline	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: Aug. 4, 1946

Where did injury occur? Harwood (City or town) M.A. (County) Md. (State)

Injured at home, farm, Industry, public place (where?): Farm

Means of injury: shot gun Injured at work? No

23. SIGNATURE: Edward R. Ritterman M.D.

Address: 199 Gloucester St. Annapolis, Md. Date signed: Aug. 6, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07709

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Trappe
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: McLAUGHLIN - CHARLES

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age ------ years
7. Birth date of deceased (mo., day, yr.): 1904

8. AGE: Years: 42 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt.
Address: Crownsville Md

19. Aug 9 1946 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 46 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 46, to August 5 19 46 and that I last saw him alive on August 5 19 46

	DURATION
Immediate cause of death: General Paresis	Known to us since 7/29/46
Due to: ------	
Due to: ------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 8/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

(159) DEATH

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation ~~or more~~ (see stub)

1. PLACE OF BIRTH:
   County: Anna Arundel Co.
   City or town: Annapolis
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Emergency Hospital
   Length of mother's stay in County: Jan. 1946
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER: 07710
   State: Maryland
   County: Anna Arundel Co.
   City or town: Lusby Cross near Annapolis
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: R. F. D. 1 Box 161
   (If RURAL give LOCATION)

3. Name of child: Sheila Ann Mc Millian
4. Date of birth: August 26, 1946 Hour: M.
5. Sex: Female
6. Twin or triplet: ***
7. No. of weeks pregnancy: 7 Months

FATHER OF CHILD

8. Full name: Caldwell McMillian
9. Color: Colored
10. Age at time of this birth: *** yrs.
11. Usual occupation: Farmer

MOTHER OF CHILD

12. Full maiden name: Sylvia Ross
13. Color: Colored
14. Age at time of this birth: 26 yrs.
15. Usual occupation: House Wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
    (b) How many other children were born alive but are now dead? None (c) How many other children were *born* dead? None

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of:
19. Labor: (a) Complications of:
    (b) Induced?
20. (a) Was there an operation for delivery? (Yes or No)
    (b) State all operations, if any:
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes:
    (b) Maternal causes: Maternal Hemmorage following long auto trip.

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: George C Boeil
    (Specify if M. D., midwife, or other)
    Address: Annapolis Md

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 8-27-1946 (month) (day) (year)
    (c) Cemetery or crematory: Fowlers Chapel Cemetery

24. (a) Funeral director: Ethel L. Hicks
    (b) Address: 43-45 Northwest Street

25. (a) Aug. 27, 1946 (Date rec'd by registrar) (b) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

Lived a few minutes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

07711 21

Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crabapple Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: [illegible]

City or town: Dundalk Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1820 Walnut Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Barbara Sue Monahan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 14th - 1942

8. AGE: Years 3 | Months 10 | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Thomas B Monahan

13. Birthplace: N J

MOTHER — 14. Maiden name: Louise McKee

15. Birthplace: Baltimore

16. Informant: Mrs Louise Monahan

Address: 1820 Walnut Ave Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Cem

Location: Rural

18. Funeral director: Selbert Funeral Home

Address: 2008 Orleans St

19. 8/13 19 46 (Date rec'd by registrar) D. W. McLeod Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 19 46 at 12 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] to Aug 12 19 46

Post mortem Examination

and that I last saw deceased on Aug 12 19 46

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8/12/46

Where did injury occur? Patapsco River Anne Arundel Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Patapsco River

Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M Caffey M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md Date signed: 8/13/46

Dun 150f

—1258R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07712 — Reg. Dist. No. 21

P. Brief

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Dundalk Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1820 Walnut Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: Thomas B. Monahan

3.(b) Social Security Number: 136-03-8523

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Lillian Monahan
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Aug 31 1918

8. AGE: Years: 27 | Months: 11 | Days: | If less than one day: hrs. min.

9. Birthplace: Millburn N J (Town, county, and state)

10. Usual occupation: Steel Carpenter

11. Industry or business:

FATHER
12. Name: Michael Monahan
13. Birthplace: N J

MOTHER
14. Maiden name: Dora Dennon
15. Birthplace: N J

16. Informant: Mrs. Lillian Monahan
Address: 1820 Walnut Ave Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 (month) (day) (year)
Cemetery or crematory: Meadow Ridge
Location: Rural

18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St

19. 8/13 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12 1946 at 12 20 P.M

21. I CERTIFY that death occurred on the date above stated: [redacted] Post mortem Examination Aug. 12 1946

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/12/46
Where did injury occur? Orchard Beach (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Patapsco River
Means of injury: Drowning Injured at work? no

23. SIGNATURE: John M. Catts M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 8/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

★ 07713 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Randall Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES MILTON MONROE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Child

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 August 1945

8. AGE: Years	Months	Days	If less than one day
1	0	3	hrs. min.

9. Birthplace: Amarillo, Potter, Texas
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Gerald Morgan Monroe
13. Birthplace: Texas

MOTHER
14. Maiden name: Margaret Joyce Moore
15. Birthplace: Oklahoma

16. Informant: Lt. Gerald M. Monroe
Address: 12 Randall St. W. Annapolis.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9, 46 (month) (day) (year)
Cemetery or crematory: U S Naval Cemetery
Location: Annapolis, Md.

18. Funeral director: B E Higgins & Son
Address: Annapolis, Md.

19. Aug 9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8, 1946 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1946 to August 8 1946 and that I last saw him alive on August 8 1946

	DURATION
Immediate cause of death: Broncho Pneumonia	2 days
Due to: Congenital Heart Disease	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: David G. Doane, M. D. or other

Address: U.S. Naval Hosp. Annapolis, Md. Date signed: 8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

07714

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hrs.
Hospital, Institution, or street address where death occurred: 410 - Old Annapolis Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Elvaton, P.O. Millersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Elizabeth Meidert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife Charles A. Meidert
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Nov. 20 - 1886

8. AGE:

Years	Months	Days	If less than one day
59	10	7	hrs. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Jacob Frederick RUEHLE
13. Birthplace Germany
MOTHER
14. Maiden name Madeline Keller
15. Birthplace Germany.
16. Informant Mrs. Charles A. Meidert
Address Elvaton, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof 8/31/46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Blvd
18. Funeral director John F. Kenny Inc
Address 715 Light St.
19. 8/27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946 at 9:50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to Aug. 27 1946
and that I last saw h alive on 8/27/46 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs.
Due to Hypertension	8 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave A. Fassler M.D.
M. D. or other
Address Glen Burnie Md. Date signed 8/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

07715

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
Parole Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ********

3.(a) FULL NAME: Viola Leuvenia Parker

3.(b) Social Security Number: 215-12- 1064

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: William Parker
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): May 27, 1924

8. AGE:

Years	Months	Days	If less than one day
22	2	15	...hrs. ...min.

9. Birthplace: Parole A. A. Co Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: James Wesley Johns
13. Birthplace: Parole Md. A. A. Co.

MOTHER
14. Maiden name: Florence Queen
15. Birthplace: Parole Md. A. A. Co.

16. Informant: James W. Johns
Address: Parole Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 16/46 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel Cemetery
Location: Best Gate Md. A. A. Co.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19 August 15 19 46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION 46 9 25

20. DATE OF DEATH: Aug. 11 19 46 at 7 P. M

21. I CERTIFY that death occurred on the date above stated: [redacted]
Post mortem Examination [redacted] Aug. 11, 19 46

Immediate cause of death	DURATION
Bullet Wound Thru	
Heart and Chest	Sudden
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 8/11/46
Where did injury occur? Parole (City or town) A. A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): at Home
Manne of injury: .45 cal. bullet Injured at work? No

23. SIGNATURE: John M. Lafferty M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 8/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07716

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: William F. Parks

3.(b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Alice Rebecca
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): April 30 1865
8. AGE: Years: 81 Months: 3 Days: 14 If less than one day: hrs. min.
9. Birthplace: Deale A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business: Oysters + Fish
FATHER 12. Name: Wm. Conley Park
13. Birthplace: Md.
MOTHER 14. Maiden name: Pences/Whittington
15. Birthplace: Md.
18. Informant: Alice R. Parks
Address: Shadyside Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 16. 1946 (month) (day) (year)
Cemetery or crematory: Gruber Cemetery
Location: Galesville Md.
18. Funeral director: V. A. Haggerty & Son
Address: Galesville Md.
19. Aug 16 1946 (Date rec'd by registrar) J. B. Dent. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 14 1946 at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to Aug 14 1946 and that I last saw h. alive on Aug 13 1946

	DURATION
Immediate cause of death: Myocardial Insufficiency	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Gangrene of toes	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Dent M. D. or other
Address: Lothian Md. Date signed 8/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07717

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Herald Harbor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 10 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County:
City or town: Miami Shores
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9325 - N.W. 2nd Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Della Payne

3.(b) Social Security Number:

4. Sex: female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: widow.

6.(b) Name of husband or wife: William Payne
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 185~~1~~ (1852)

8. AGE: Years: 93 | Months: 9 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Delaware U.S.A.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Mr. M. C. Thompson
Address: Herald Harbor, Crownsville, Md

17. removal (Burial, cremation, or removal. Which?) Date thereof Aug 26 1946 (month) (day) (year)

Cemetery or crematory: Congressional Cemetary
Location: Washington D.C.

18. Funeral director: W.W. Chambers Co
Address: 519-11th St. se Wash, D.C.

19. Aug 26 1946 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 1946 at 7 45 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~The attended deceased from~~ Post mortem, Examination
~~Last saw alive~~ 19

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Arterio. Sclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work? Deputy Medical Examiner

23. SIGNATURE: John M. Coffey M.D. M. D. or other
Address: Annapolis, Md. Date signed 8/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07718

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Arnold Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Ann Arundel
City or town: Arnold Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sterling Porter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1928

8. AGE: Years	Months	Days	If less than one day
18	5	30	..... hrs. ..... min.

9. Birthplace Arnold, A. A. Co. Md.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business

FATHER
12. Name Vernon Porter
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden name Maggie Watts
15. Birthplace A. A. Co. Md.

16. Informant Maggie Porter
Address Arnold Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7, 1946 (month) (day) (year)
Cemetery or crematory Broadneck
Location Baltimore, Md.
18. Funeral director C. B. Johnson
Address Annapolis Md.

19. August 6, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1946, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26- 1946 to 5-14 1946
and that I last saw h[illegible] alive on 5-14-46 1946

Immediate cause of death	DURATION
Hemorrhage	
Due to Pul Tuberculosis	.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. T. Talley M D
M. D. or other
Address 17 Cruise St. Date signed 5-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

07719

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Johann Riedel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 13, 1870

8. AGE:

Years	Months	Days	If less than one day
76	3	30	..... hrs. ..... min.

9. Birthplace: Czechoslovakia
(Town, county, and state)
10. Usual occupation: Retired Textile worker
11. Industry or business

FATHER
12. Name: Joseph Riedel
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden name: Theresa Stuerm
15. Birthplace: Czechoslovakia

16. Informant: Brother - Joseph Riedel
Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Washington, D. C.
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.
19. August 13, 1946 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12 1946 at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Aug. 10 1946 and that I last saw h...m alive on Aug. 10 1946

	DURATION
Immediate cause of death	
Cardio-renal Disease	2 years
Due to: Arterio-sclerosis	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 8/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07720

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Emergency Hospital Annapolis
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Short Acres
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: John A. Rosenberger

3.(b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widower
6.(b) Name of husband or wife: Mary Rosenberger
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 17, 1867
8. AGE: Years: 79 Months: 5 Days: 6 If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Truck Farm
FATHER 12. Name: John Rosenberger
13. Birthplace: Bavaria Germany
MOTHER 14. Maiden name: Eva Schlipper
15. Birthplace: Bavaria Germany
16. Informant: John L. Becker
Address: Arnold, Maryland
17. Removal (Burial, cremation, or removal, Which?) Date thereof: Aug 23 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md.
18. Funeral director: Henry W. Jenkins Son, Inc.
Address: Baltimore, Md
19. Aug 23 1946 (Date rec'd by registrar) Registrar: [signature] W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23. 1946, at 7:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1946 to Aug. 23 1946 and that I last saw h.. alive on Aug. 23 1946

	DURATION
Immediate cause of death:	
Carcinoma of liver	
Due to: gall-bladder and	
Due to: pancreas.	not known
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: as above
Date of op. Aug. 16. 43
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Clatty M.D.
M. D. or other
Address: Annapolis Md. Date signed: 8/23/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07721

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Arnold Md rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Arnold rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rudolph Henry Rupp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Anna Marie

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 26 - 1867

8. AGE: Years: 78 | Months: 9 | Days: 19 | If less than one day: ... hrs. ... min.

9. Birthplace: Trakuna, Baden, Germany (Town, county, and state)

10. Usual occupation: Farming (retired)

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: William Rupp

Address: Arnold Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 18th 46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor (Est of Son)

Address: Annapolis Md.

19. Aug 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1946, at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to August 15 1946

and that I last saw him alive on August 15 1946

Immediate cause of death	DURATION
Cardiac failure	
following	
Arteriosclerosis	
Due to: Gangrene left leg	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard R Bohlman M.D. M. D. or other

Address: Medical Arts Bldg Baltimore Md Date signed Aug 15 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5-18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07723 23
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 902 Sarah Ann St.
(If rural, give LOCATION) Sarah Ann St
2.(a) If veteran, name war: ✓

3.(a) FULL NAME George Rustin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	separated

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
46	-	19	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Grant Rustin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eleanor Brown
15. Birthplace: Md.

16. Informant: ~~Mrs Viola Fuss~~ Hospital Records
Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/46 (month) (day) (year)
Cemetery: Mt. Calvary
Location: Cedar Hill Md.

18. Funeral director: A. Halstead
Address: 918 Druid Hill Ave.

19. 9-3 46 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1946, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1946, to August 31 1946
and that I last saw h... alive on August 31 1946

Immediate cause of death	DURATION
General Paresis	Known to me August 5 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

07723

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs, 4 mos, 16 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 15 yrs, 4 mos, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ———

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1110 McCulloh Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3. (a) FULL NAME: SALISBURY - MARY

3. (b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years: 50 | Months: unknown | Days: | If less than one day: ——— hrs. ——— min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ———

FATHER — 12. Name: unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: Bettie Salisbury

15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof: 8/18/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt. - Hospital

Address:

19. (Date rec'd by registrar) Aug 24 1946 E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 19 46, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 31, to Aug. 17 19 46

and that I last saw h... alive on ... 19...

Immediate cause of death: Cerebral Hemorrhage — DURATION: Known to us since 7/12/46

with

Right-Sided Hemiplegia

Due to: ———

Due to: ———

Other conditions: Psychosis with Mental Deficiency — Known to us since 3/31/31

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.: ———

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of: ———

Where did injury occur? (City or town) (County) (State) ———

Injured at home, farm, industry, public place (where?): ———

Means of injury: ——— Injured at work? ———

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 8/17/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(159)

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland a. a. C.

(b) Street address 219 Meadow Rd

(c) Hospital or institution: Brooklyn, Md

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 07724

(a) State Ind. (b) County

(c) City or town Fort Wayne
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1002 Colerick St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Boy Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race wh.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1946

8. AGE: Years | Months | Days | If less than one day 1 hr. 15 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Morris Oliver Schaefer

13. Birthplace Grafton W. Va

MOTHER 14. Maiden Name Anna Muriel Ringler

15. Birthplace Balto, Md

16 (a) Informant Mrs. Morris O. Schaefer

(b) Address 219 Meadow Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Schoo AUG 27 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/ 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8/27/ 1946 and that I last saw h. alive on 8/27/ 1946

Immediate cause of death	Duration
2.	
Due to Premature labor	
Due to	
Other Conditions Deformity of left forearm and hand	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. Weinberger M. D.

Address 912 Brooklyn Ave. Date signed 8/27/46

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 037252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11 Ridout St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Daisy Smith Simms

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	married

6.(b) Name of husband or wife: John Simms
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb. 15 1888

8. AGE:

Years	Months	Days	If less than one day
58	6	12	..... hrs. ..... min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Henry Smith
13. Birthplace: Md.
MOTHER 14. Maiden name: Sarah Smith
15. Birthplace: Md.
16. Informant: John Simms
Address: 11 Ridout St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
16. Funeral director: J. B. Johnson
Address: Annapolis
19. Aug. 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH: Aug 27 1946, at 1245 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to Aug 26th 1946, and that I last saw her alive on Aug 26th 1946

Immediate cause of death	DURATION
Pneumonia	5 days
Due to	
Due to	
Other conditions: Paralysis	6 mos

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. T. Russell M.D. (M. D. or other)
Address: Eastport Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

07726

Reg. Diat. No. 281

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs, 10 mos, 20 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs, 10 mos, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore City Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: SMITH - DAISY

3.(b) Social Security Number: ------

4. Sex: female
5. Color or race: black
6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years: 52 Months: unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ------

FATHER
12. Name: Charles Elliott
13. Birthplace: unknown

MOTHER
14. Maiden name: Harriet Gaines
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/9-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Supt.
Address: Crownsville Md

19. Aug 9 19 46 (Date rec'd by registrar) E D Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 46 at 5:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 19 41 to Aug. 5 19 46 and that I last saw her alive on August 5 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 9/15/41
Due to: ------	
Due to: ------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operation: ------ Date of op. ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: Robert V. Hinkelmann M. D. or other
Address: Crownsville, Maryland Date signed 8/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56-2

CERTIFICATE OF DEATH

P 7727

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edwina Ruther Webster Stubbs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Rev. Francis Horatio Stubbs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1864

8. AGE:	Years	Months	Days	If less than one day
	81	9	21	..... hrs. ..... min.

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Dr. Henry Worthington Webster

13. Birthplace: Md.

MOTHER

14. Maiden name: Catherine E. Rayther

15. Birthplace: Phila. Pa

16. Informant: Mr. Charles L. Adams

Address: 910 Central Pky. Schenectady N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/12/46 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Balto. Md.

18. Funeral director: John O. Mitchell Sons

Address: 1900 Eutaw Place

19. 8/12 19 46 (Date rec'd by registrar) A W Fedrick Registrar

J. C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10, 1946, at 11.50 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 2/10/46 to 8/10/46 and that I last saw h.. alive on 8/8/46

	DURATION
Immediate cause of death: generalized carcinomatosis.	6 mos (?)
Due to: Carcinoma of neck (origin unknown)	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Bornstein MD (M. D. or other)

Address: Annapolis Md Date signed: 8/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

07662

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Raynor Heights, P.O. Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about one day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. City or town: Lakeside Park, P.O. Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 9 - Box 459

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Louis Fates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	Single.

6.(b) Name of husband ~~or wife~~

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug - 5 - 1935

8. AGE: Years: 11 | Months: | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Pupil (School)

11. Industry or business

FATHER 12. Name: William Henry Fates

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Bessie Willis

15. Birthplace: Virginia

16. Informant: Wm. H. Fates (father)

Address: 929 - Shields Place, Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 - 46 (month) (day) (year)

Cemetery or crematory: Mt. Calvery, Cem.

Location: Brooklyn, Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley ave

19 Aug 14 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 - 19 46, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Accidental Drowning	
Due to: Found in the A. A. Corporation	
Due to: Pond - off Nursery Road	
Due to: Raynor Heights	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8/7/46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave N. Faulenbruch M. D. or other

Address: Glen Burnie, Md. Date signed 8/9/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-0)

07728

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Severn, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: John Henry Thames

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Alice T Thames
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1884

8. AGE: Years: 62 | Months: 2 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hills Bridge, Pr Geo, Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Robert John Thames
13. Birthplace: So. Carolina

MOTHER
14. Maiden name: Sarah Ann Shepherd
15. Birthplace: So Carolina

16. Informant: Lottie Norfolk
Address: 1509 Ellamont St. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-6-46 (month) (day) (year)

Cemetery or crematory: M. Calvary
Location: Severn Md

18. Funeral director: Pitcher Bros
Address: Upper Marlboro Md.

19. Aug 5th 46 (Date rec'd by registrar) W P Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 Aug 1946 at 7 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 June 1946, to 4 Aug 1946 and that I last saw h. l. m. alive on 2 Aug 46 1946

Immediate cause of death	DURATION
Bronchogenic Carcinoma	Unknown
right & metastases	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: Bronchogenic Carcinoma - oat cell type Date of op. 2 July 46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R P Trasser M. D. or other
Address: Upper Marlboro, Md Date signed 4 Aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07729 Reg. Dist. No. 21

8

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Orchard Beach - P.O. Curtis Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: [illegible]
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Lillie Charlotte Thompson.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Willard E. Thompson.
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): January 15 - 1891

8. AGE: Years: 55 Months: 7 Days: 24 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: William Connelly
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Marguerite Waschmuth
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Wm. E. Thompson (husband)
Address: Orchard Beach, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12-1946 (month) (day) (year)
Cemetery or crematory: London Park
Location: 3601 Frederick Ave.
18. Funeral director: Mrs. Mrs. John W. Teufel & Sons
Address: 801 W. Fayette St.

19. Aug 10 1946 (Date rec'd by registrar) A.W. Kibrid per a.m.s. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1946, at 1 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Strangulation	Instan.
Due to: Suicide.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8/8/46
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Shed (Home).
Means of injury: Hang with rope. Injured at work? No

23. SIGNATURE: Gustave H. Faulenbach M.D.
acting medical examiner M. D. or other
Address: Glen Burnie, Md. Date signed: 8/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Change of address authorized by undertaker, who is personally acquainted with informant and deceased. House in Balto.City sold 4 years ago. ams 8-10-46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07730

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 40 Pleasant St
How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 40 S Pleasant St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clifton Tongue

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Agnes Tongue
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 19 1890

8. AGE: Years	Months	Days	If less than one day
56	3	1	hrs. min.

9. Birthplace: Mt Zion (West River)
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Jerry Tongue
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Tongue
15. Birthplace: Md
16. Informant: Agnes Tongue
Address: 40 Pleasant St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Stamper
Address: Annapolis
19. August 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1946, to Aug 16 1946
and that I last saw h. alive on Aug 15 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. McLaurans, Md M. D. or other
Address: 71 Smith Gate Ave Date signed: 8/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

07731

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 5 mos, 20 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yr, 5 mos, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1505 North Dallas Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

3.(a) FULL NAME: TRAYNHAM - WILLIAM

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Frances Traynham, 406 Maple Lane, Dundalk, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): December 25, 1871

8. AGE:

Years	Months	Days	If less than one day
74	7	27	---hrs. ---min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Thomas Traynham
13. Birthplace: unknown

MOTHER
14. Maiden name: Adaline Wade
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug. 26, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel County

18. Funeral director: Mrs. Robert Elliott & Daughter

Address: 1129 N. Caroline St., Balto., Md.

19. 8/26/46 (Date rec'd by registrar) Accepted Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 19 46 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 45 to Aug. 22 19 46 and that I last saw him alive on August 22 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	16 days
Due to: ------	
Due to: ------	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 3/2/45

Major findings of operations: ---------

Date of op. ---------

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---------

Means of injury: ---------- Injured at work? ---------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 8/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

07732

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anna Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~12 Randall St~~ 37 yrs

Hospital, institution, or street address where death occurred:
12 ~~Randall~~ Prince Street, Annapolis, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 ~~Randall~~ Prince Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ETHEL C. TREADWAY

3.(b) Social Security Number ---- -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Charles H.

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1884

8. AGE:	Years	Months	Days	If less than one day
	61	9	12	-- hrs. -- min.

9. Birthplace Portsmouth, New Hampshire
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business --- -------

FATHER
12. Name Adolph Robeck
13. Birthplace Germaney

MOTHER
14. Maiden name Mary W. Schwallenberg
15. Birthplace Baltimore, Maryland

16. Informant Mr. Charles H. Treadway
Address 12 ~~Randall~~ Prince St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17, 46 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Annapolis, Maryland

18. Funeral director B.L. Hopring & Son

Address Annapolis, Maryland

19. Aug. 17, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 45, to Aug 15 19 46 and that I last saw her alive on Aug 15 19 46

Immediate cause of death	DURATION
Myocarditis acute	3 weeks
Due to Carcinoma Stomach	1 year.
Due to Chronic Arthritis	Indefinite
Other conditions Arteriosclerosis	Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boak M. D. or other

Address Annapolis Md Date signed 8. 16. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

Reg. Dist. No. 07733 23

1. PLACE OF DEATH:

County a. a.

City or town Glenarmonie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Glen Burnie (Oakwood)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oakwood Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Thomas Vest.

3.(b) Social Security Number 215-09-7487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Myrtle M. Vest Nee Ewing

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) April 15, 1891

8. AGE: Years	Months	Days	If less than one day
55	4	9	....hrs. ....min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual occupation Warehouse Foreman

11. Industry or business Bethlehem Fairfield.

FATHER 12. Name Joseph Edgar Vest

13. Birthplace Richmond Va

MOTHER 14. Maiden name Emma I Haydie

15. Birthplace Richmond, Va

16. Informant Mrs. Joseph T. Vest

Address Glen Burnie, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 27, 1946 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md

18. Funeral director Thomas W. Pinglton

Address Glen Burnie, Md.

19. Aug 26 1946 (Date rec'd by registrar) Mrs. Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1946 at 9:17 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to Aug 24 1946 and that I last saw him alive on Aug 24 1946

Immediate cause of death	DURATION
Tumor (Glioma) Brain	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas L. Baer Jr M. D. or other

Address Littleton Date signed 8-24-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Anna Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 34 Pleasant
How long in hospital or institution? ——

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anna Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Pleasant Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Weems

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Martha Weems
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	22	____ hrs. ____ min.

9. Birthplace: Anna Arundel Co. (Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business: None

FATHER
12. Name: Lewis Weems
13. Birthplace: Anna Arundel

MOTHER
14. Maiden name: Georgianna Kent
15. Birthplace: Anna Arundel Co.

16. Informant: Hattie Taylor
Address: 82 Calvert Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-46 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. August 23 19 46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19-46 19 ____ at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3 19 46 to 8-19-46 19 ____ and that I last saw him alive on 8-12-46 19 ____

Immediate cause of death	Gastro-enteritis	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: A. T. Allen M.D. M. D. or other
Address: 17 Conduit St Date signed: 8-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100-a)

CERTIFICATE OF DEATH

07735

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cathedral Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosalie Viola White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-26-04

8. AGE:

Years	Months	Days	If less than one day
41	11	25	..... hrs. ..... min.

9. Birthplace: Memphis, Tennessee

(Town, county, and state)

10. Usual occupation: Charwoman

11. Industry or business

FATHER

12. Name: Charles A. White

13. Birthplace: Annapolis, Md.

MOTHER

14. Maiden name: Rose M. Morgan

15. Birthplace: Annapolis, Md.

16. Informant: Arthur White

Address: Chesapeake Ave Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. August 23 19 46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 19 46, at 1.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 19 46, to Aug 20 19 46 and that I last saw h.. alive on Aug 20 19 46

Immediate cause of death	DURATION
Pulmonary Emphysema	
Shock	
Due to: Heart Failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Eastport, Md. Date signed 8-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

(7736

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs, 3 mos, 6 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs, 3 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3. (a) FULL NAME: WHITMORE - ADDIE

3. (b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years: 84 | Months: unknown | Days: | If less than one day: ——— hrs. ——— min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which? burial Date thereof 8/19/46 (month) (day) (year)
Cemetery or crematory: Old Public
Location: Crownsville Md

18. Funeral director: Supt
Address: Crownsville

19. 8/19/46 (Date rec'd by registrar) Est. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 19 46 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 19 42 to August 13 19 46 and that I last saw her alive on August 13 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 5/7/42
Due to: ———	
Due to: ———	
Other conditions: Senile Psychosis	Known to us since 5/7/42

(Include pregnancy within 3 months of death)

Major findings of operation: ——— Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert V. Strickroot M. D. or other
Address: Crownsville, Maryland Date signed 8/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

07737

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Anne Arundel Co.
County
Annapolis
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 87 Calvert Street
How long in hospital or institution? ***

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 87 Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Joseph Williams

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1899

8. AGE: Years	Months	Days	If less than one day
47	1	27	hrs. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business None

FATHER
12. Name Bennie Williams
13. Birthplace Prince George Co.

MOTHER
14. Maiden name Martha Mordark
15. Birthplace Annapolis, Md.

16. Informant Martha Williams
Address 87 Calvert Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-46 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location West Street Extended

18. Funeral director Ethel L. Hicks
Address 43-45 Northwest Street

19. Aug. 28, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/46, 19..., at 330 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1946, to Aug 24, 1946 and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Aortic Insufficiency	1 yr.
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Theodore L. Johnson Jr. M. D. or other
Address 40 Northwest Street Date signed 8/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

117738

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs, 11 mos, 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 8 yrs, 11 mos, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 North Dallas Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3.(a) FULL NAME WILSON - JOHN H.

3.(b) Social Security Number -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years: 73 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER
12. Name: Dan Wilson
13. Birthplace: unknown

MOTHER
14. Maiden name: Frances Simms
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt, Crownsville Md.

Address

19. 8/9/46 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1946, at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1937 to August 8 1946

aed that I last saw h... im ... alive on August 8 1946

	DURATION
Immediate cause of death: Chronic Myocarditis	6 months
Due to: -------	
Due to: ------	
Other conditions: Paranoid Condition	Known to us since 9/6/37

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op. --------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ---------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? --------

23. SIGNATURE: Herbert J. Brueckner M. D. or other

Address: Crownsville, Maryland Date signed: 8/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★07739 Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 21 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME YOUNG - ROBERT

3.(b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1868 ?

8. AGE: Years	Months	Days	If less than one day
78?	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: John Young
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Busk
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Longgreen, Maryland

18. Funeral director: Mrs. Francis T. Hemsley

Address: 578 W. Biddle Street, Balto., Md.

19. 8-20-46 (Date rec'd by registrar) 19.... E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 19 46, at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 46, to August 20 19 46 and that I last saw him alive on August 20 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 5/29/46
Due to: ---	
Due to: ---	
Other conditions: Arteriosclerotic Gangrene; Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 5/29/46

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? (City or town) (County) (State) ---

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert L. Hinkwood M. D. or other

Address: Crownsville, Maryland Date signed: 8/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M